

# Use of a Medication History Form for Practice and Teaching Applications

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## *INTRODUCTION*

Increasing health care specialization has created a unique opportunity for the pharmacist to become the one health care provider who can coordinate a patient's drug therapies, monitor drug interactions, evaluate side effects, and gauge the appropriateness of therapy. One of the tools necessary to ensure that all facts of medication therapy are obtained is a medication history form. Several sources have indicated that pharmacists, when conducting the medication review, obtain a more thorough picture of the patient's medication history than any other health care professional (1-3). Although several medication forms have been developed for use in obtaining patient medication histories, none has listed specific questions to ask a patient as part of the form (4). The "Record of Medicines Form" by the One Minute Counselor lists some questions but may not provide enough detail to remind patients of what they actually use (5).

## *DESCRIPTION OF MEDICATION HISTORY FORM*

Communicating clearly and specifically to patients when obtaining a history is necessary to account for the complete patient medication therapy. A medication history form was developed by the

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author to assist in this communication process (Appendix A). The author was a member of a geriatric assessment team, and the form was used for intake on all patients receiving an assessment. In teaching pharmacy students the importance of obtaining a thorough medication history from their patients, it became apparent that students in their third year of school did not know how to take a medication history. It was then determined to incorporate this information into a communication skills class and to use the above-mentioned form as a template for the interview style to be used in obtaining medication histories.

This medication history form was designed specifically to identify routinely used medications, over-the-counter (OTC) medications, dietary and social habits, allergies and adverse drug interactions, and significant past medical history. What makes this form unique is that the questions to be asked of the patient are written on the form as a guide for the interviewer. This was done to allow other health care professionals to use the form and gather the same type of data from a patient in the event a pharmacist is not present. Closed- and open-ended questions are written below each key word or phrase used to describe the type of information sought on the form.

Open-ended questions have been referred to as patient-centered questions (6). These questions require more than a yes or no response and do not predispose the patient to the interviewer's frame of reference. A question may, however, assume that the patient does use or would take one of the products identified. The closed-ended questions are for items not routinely considered as common self-medicating therapy and use the yes or no response format. Additional questions can be asked by the interviewer if he or she feels it is necessary to obtain more information.

## DISCUSSION

The medication history form begins with the patient's name. No other personal information is obtained for the form because it is assumed that the pharmacist using this form has access to the patient's chart or other profile system. The first section is a list of the name, dose, strength, and directions for use of any medication that the patient takes routinely. The patient may state any prescription or OTC

medication he or she takes. When possible, this information is compared with the information listed on the patient's prescription containers.

Many have noted the importance of obtaining OTC drug information as part of a medication history (4, 7, 8). The next section on the medication history form lists specific OTC categories with questions to obtain more detailed information. Some underlying diseases are assumed (i.e., colds, aches and pains, constipation, insomnia). Instead of asking closed-ended questions such as "Do you take analgesics?" which could be used given the prompt word of analgesic, the question is "What do you take for minor aches and pains?" This format allows the patient to respond with a specific product and not just a yes or no answer. The patient's response is then followed up by the interviewer with the prompts from the heading of use and frequency.

The next group of questions deals with the social and dietary habits of the patient. A closed-ended question is asked to determine if the patient needs an appetite stimulant or suppressant at mealtime. An open-ended question of how much coffee, tea, or pop the patient consumes addresses the topic of caffeine intake. Questions about alcohol are asked with the assumption that the patient does drink something. If the patient responds that he or she does not drink, the patient is again prompted with "Ever before dinner or to get to sleep?" This type of question leads to a more relaxed and truthful response than a leading question of "You don't drink, do you?" Smoking history is also important, and initial yes or no responses set the stage for the need for additional questions.

The next section of the medication form identifies a list of medications that the patient reports have caused an allergic condition or an adverse reaction in the past. The patient is asked to name the drug and the symptom or reaction that occurred. The last section is for use by the pharmacist (or other interviewer) to write comments and suggestions about the information obtained.

## **APPLICATIONS OF THE FORM**

### ***Case Histories of Use by Pharmacists***

Pharmacists using this form as part of the geriatric assessment have indicated many factors that make this tool beneficial. Discre-

pancies between directions given by patients and what was printed on prescription labels or patient medical charts were clarified with the prescribing physician. Medications written for routine use were reportedly taken when needed, and those written for prn use were taken routinely. It was found that patients frequently take their medication other than as prescribed due to daily habits or how they feel. Analgesics were taken more often than prescribed because the effect of the medication was felt by the patient. In several cases, duplicate prescriptions were written by different physicians, resulting in increased medication use (i.e., Darvocet-N 100<sup>R</sup> 2 tabs qid for pain and Darvocet-N 100 2 tabs at hs prn). In some cases, problems with levothyroxine use were found when it was discovered that the patient only took the medication when he or she felt tired. In another case, problems of generic substitution when brand-name medications were thought to have been dispensed were discovered. In all of these cases, changes in patient outcomes were identified which resulted from alterations in expected blood levels of some drugs. Because the prescriber was informed of these differences, subtherapeutic drug blood levels did not require increases in medication but education on compliance with an existing regimen or a switch back to brand-name products.

Several patients used OTCs routinely but did not refer to them as medications because they could purchase these drugs without a prescription. Other patients gave examples of Darvocet-N 100 and Tylenol with Codeine #3 as analgesics used for pain. These drugs had not been mentioned previously under routine medications and could have been missed if the question had not been asked as stated.

The question format for caffeine, alcohol, and smoking did not appear to offend patients. One patient even admitted to the pharmacist that a drinking problem existed even though family members observed this person as a teetotaler. Other patients who have seemed reluctant to state that they may drink occasionally usually respond to the questions about drinking before dinner indicating their consumption of occasional glasses of wine. In questioning patients about tobacco use, the pharmacist would often ask if the patient was exposed to secondary smoke on a routine basis. In general, information received about caffeine, alcohol, and tobacco

was usually followed with educational information for the patient about how these substances affected the medication regimen.

It is interesting to note that when patients were asked questions about allergies several patients responded with affirmative replies about hay fever and ragweed. When the question specifically asked about adverse drug reactions, the patients would offer reactions of a rash associated with penicillin or other drug use.

The significant past drug history is obtained to gather information the patient may have that was not indicated in his or her current chart. The additional comments and suggestions section allowed a place for the pharmacist to write impressions of the interaction with the patient. Nonverbal cues that described the patient's outward appearance during the interview were recorded. This section also allowed the pharmacist to assess whether he or she believed the patient appeared competent or capable of compliance with the dosage regimen based on comments and information obtained during the interview process.

### ***Student Feedback***

Teaching students how to take medication histories was incorporated into the patient interview section of a communications skills course offered in the first professional year of pharmacy school. This form, along with other medication history forms, was introduced as a resource for students to use in conducting medication histories. The technique of interviewing patients was discussed, as well as the value of open-and closed-ended questions.

The use of this form appears favorable, since students who are required to conduct medication histories as part of some of their clerkship experiences often handed in medication history assignments using a copy of this question-prompting form which they received in their first professional year. Although no quantitative data has been collected, clinical faculty and clerkship preceptors have also commented that the form appears thorough and well constructed.

### ***SUMMARY***

Pharmacy students are often expected to take a medication history as part of their clerkship experience, many times without much

direction except for a skeleton form with some key words. If pharmacists are to continue to receive more information about patients' medication histories than other health care professionals, then pharmacy students must be taught appropriate techniques to use in taking a medication history. It is not the form that makes the difference in the interview process, but how many and what types of questions are asked. This medication history form serves as a constant reminder to use open-ended questions in an interview process. If students are provided with a form that outlines questions for them, they will learn the interviewing technique using the open-ended question format. They will then be able to apply that same type of question when given a different, skeleton medication history form that may be site specific.

We often expect a certain product from students when they obtain information from patients, but we may not always provide students with the tools necessary to complete the task. This form is an attempt to educate the interviewer to conduct an effective patient medication history when he or she may not have received the communication background necessary for successful patient interviewing. It also serves as a practical training device by providing students with a "real world" tool that will be beneficial in their upcoming practices. By teaching students to use the learning interview type questions on the form, we will be assured that the pharmacists of the future will continue to play a significant role in obtaining patient medication histories.

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APPENDIX A  
MEDICATION HISTORY

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

ROUTINE MEDICATIONS CURRENTLY TAKING

<u>NAME OF DRUG</u>	<u>DOSE/STRENGTH</u>	<u>SIG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NONPRESCRIPTION DRUGS

	<u>NAME OF DRUG</u>	<u>USE/FREQUENCY</u>
Cold/Allergy products	_____	_____
(What do you take when you have a cold/hay fever?)	_____	_____



Analgesics \_\_\_\_\_  
(What do you take for minor aches/pains?)

Antacids \_\_\_\_\_  
(What do you take for an upset stomach/heartburn?)

Laxatives \_\_\_\_\_  
(What do you take for constipation?)

Sleeping Aids \_\_\_\_\_  
(What do you take at night when you can't sleep?)

Externals/Topicals \_\_\_\_\_  
(Do you use any creams/lotions on your skin?)

Ophthalmics \_\_\_\_\_  
(Do you ever use any eye drops for dry/irritated eyes?)

Otics \_\_\_\_\_  
(What ear drops do you use?)

Home Remedies \_\_\_\_\_  
(Do you mix up any remedy that you use, e.g., sugar and honey for a sore throat?)

Vitamins \_\_\_\_\_

Iron Supplement \_\_\_\_\_

Stimulants \_\_\_\_\_  
(Do you ever use anything to keep awake, e.g., NoDoze?®)

## Dietary Aids \_\_\_\_\_

(Do you use any aids to stimulate or suppress your appetite or increase your calories, e.g., Ensure®, Aids®?)

## Caffeine Intake \_\_\_\_\_

(How much coffee/tea/pop do you drink?)

## Alcohol Intake \_\_\_\_\_

(How much alcohol do you drink? Ever before dinner or to get to sleep?)

## Smoking History \_\_\_\_\_

(Do you smoke? Did you ever? How much? For how long? Do you chew or use snuff? Did you ever?)

## Hormone History \_\_\_\_\_

(Were you ever on birth control pills? How long? Other hormones?)

Allergies/Adverse Drug Reactions

DRUG/IRRITANT

SYMPTOM/REACTION


Significant Past Drug History

What drugs do you remember taking for a long period of time? (heart medications, tranquilizers, steroids, NSAIDs, etc.)

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COMMENTS/SUGGESTIONS:

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